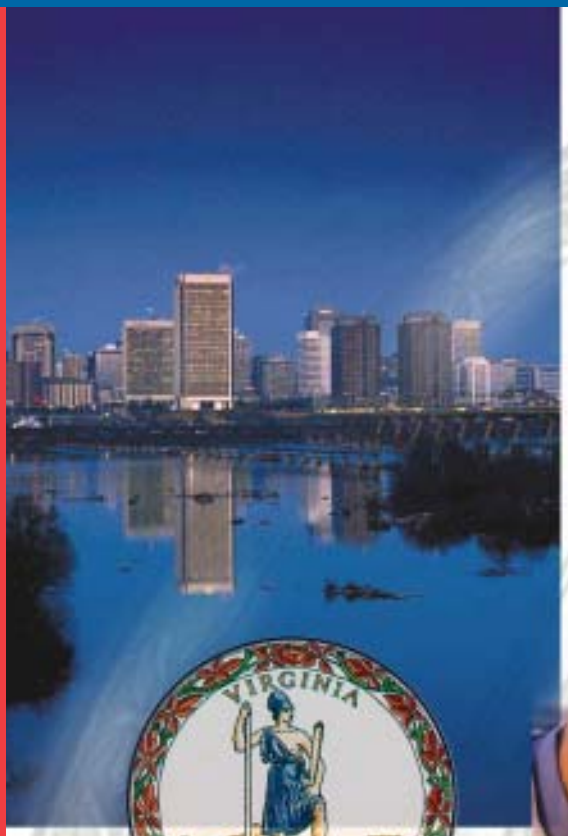
delmarva foundation



Commonwealth of Virginia Department of Medical Assistance Services

External Quality Review

Southern Health Services/CareNet

Annual Report 2005

We don't provide healthcare... we make it better.

Southern Health Services/CareNet Annual Report

Introduction and Purpose

The Virginia Department of Medical Assistance Services (DMAS) is charged with the responsibility of evaluating the quality of care provided to recipients enrolled in contracted Medallion II managed care plans. The intent of the Medallion II program is to improve access to care, promote disease prevention, ensure quality care, and reduce Medicaid expenditures. To ensure that the care provided meets acceptable standards for quality, access, and timeliness, DMAS has contracted with the Delmarva Foundation for Medical Care, Inc. (Delmarva) to serve as the External Quality Review Organization (EQRO).

Following federal requirements for an annual assessment, as set forth in the Balanced Budget Act of 1997 (BBA) and federal EQRO regulations, Delmarva has conducted a comprehensive review of Southern Health Services/CareNet (CareNet) to assess the plan's performance relative to the quality of care, timeliness of services, and accessibility of services.

For purposes of assessment, Delmarva has adopted the following definitions:

- **Quality,** stated in the federal regulations as it pertains to external quality review, is "the degree to which a Managed Care Organization (MCO) or Prepaid Inpatient Health Plan (PIHP) increases the likelihood of desired health outcomes of its recipients through its structural and operational characteristics and through the provision of health services that are consistent with current professional knowledge" ("Final Rule: External Quality Review," 2003).

- **Access** (or accessibility), as defined by the National Committee for Quality Assurance (NCQA), is the "timeliness in which an organization's member can obtain available services. The organization must be able to ensure accessibility of routine and regular care and urgent and after-hours care" ("Standards and Guidelines," 2003).

- **Timeliness,** as it relates to utilization management decisions, is defined by NCQA as when "the organization makes utilization decisions in a timely manner to accommodate the clinical urgency of the situation. The intent is that organizations make utilization decisions in a timely manner to minimize any disruption in the provision of health care" ("Standards and Guidelines," 2003). An additional definition

of timeliness given in the National Health Care Quality Report "refers to obtaining needed care and minimizing unnecessary delays in getting that care" ("Envisioning the National Health Care," 2001).

This annual report provides an evaluation of data sources reviewed by Delmarva as the EQRO to assess the progress that Medallion II managed care plans have made in fulfilling the goals of DMAS. This annual report is a mandated activity in the Medallion II contract and the BBA External Quality Review regulations.

Although Delmarva's task is to assess how well CareNet performs in the areas of quality, access, and timeliness from Health Employer Data and Information Set (HEDIS®[1]) performance, performance improvement projects, and operational systems review perspective, it is important to note the interdependence of quality, access, and timeliness. Therefore, a measure or attribute identified in one of the categories of quality, access, or timeliness also may be noted under either of the two other areas.

Quality, access, and timeliness of care are expectations for all persons enrolled in the Medallion II managed care program. Ascertaining whether health plans have met the intent of the BBA and state requirements is a major goal of this report.

Background on Plan

CareNet provides managed care services to Medallion II enrollees in various localities throughout the state of Virginia. Enrollment in 2004 for CareNet health plan was 16,123 members. Localities covered by CareNet are Tidewater and Central Virginia regions. CareNet began providing services to Medallion II enrollees in January 1999 and is an NCQA accredited health plan with a commendable accreditation status.

Data Sources

Delmarva has used the following three data sources to evaluate CareNet's performance:

- HEDISperformance measures, which are a nationally recognized set of performance measures developed by NCQA. These measures are used by health care purchasers to assess the quality and timeliness of care and service delivery to members of managed care delivery systems.
- Summaries of plan-conducted Performance Improvement Projects (PIPs).
- Operational systems review consisting of a desk review conducted by Delmarva as the EQRO to reassess deficient elements from the previous year's onsite review for compliance with contract requirements and state regulations.

[1] HEDIS ® is a registered trademark of the National Committee for Quality Assurance (NCQA).

Methodology

Delmarva performed an external independent review of all data from the above-listed sources. The EQRO has assessed quality, access, and timeliness across the three data disciplines. After discussion of this integrated review, Delmarva will provide an assessment to DMAS regarding how well the health plan is providing quality care and services to its members.

Health plan HEDIS results are audited by NCQA-licensed organizations. The HEDIS data in this report have been audited by MedStat through Delmarva. The BBA requires that performance measures be validated in a manner consistent with the External Quality Review protocol *Validating Performance Measures*. Each audit was conducted as prescribed by NCQA's *HEDIS 2005, Volume 5: HEDIS Compliance Audit™: Standards, Policies and Procedures* and is consistent with the validation method required by the EQRO protocols. NCQA protocols are used to capture and compute HEDIS results. This report contains data results of common HEDIS measures, each of which is calculated by all Medallion II managed care plans[2]

During the HEDIS 2005 reporting year, CareNet collected data from calendar year 2004 related to the following clinical indicators as an assessment of quality, access, and timeliness:

- Childhood Immunization Status
- Adolescent Immunization Status
- Breast Cancer Screening
- Prenatal and Postpartum Care
- HEDIS/CAHPS 3.0H Adult Survey
- Well-Child Visits in the First 15 Months of Life
- Well-Child Visits in the Third, Fourth, Fifth, and Sixth Year of Life
- Adolescent Well-Care Visit

PIPs also are used to assess the health plan's focus on quality, access, and timeliness of care and services. Although the PIPs address clinical issues, barrier analysis often leads to the identification of issues regarding access or timeliness as major contributing factors that affect the attainment of the clinical quality goals. CareNet submitted two PIPs for review. Delmarva reviewed the health plan's PIPs, assessed compliance with DMAS contractual requirements, and validated the activity for interventions as well as evidence of improvement. The PIP topics were as follows:

- Increasing Adolescent Immunization Rates
- Increasing the Number of Members With Asthma to Receive Care According to the Guidelines

The CareNet Operational Systems Review covered activities performed during the time frame of Jan. 1, 2004 through December 31, 2004 and focused on elements which were found to be deficient (elements partially

[2] The NCQA HEDIS Compliance Audit is a trademark of NCQA.

met or not met) in the previous years' onsite review. The purpose is to identify, validate, quantify, and monitor problem areas in the overall quality assurance program. The review incorporated regulations set forth under the final rule of the BBA that became effective on August 13, 2002. The BBA is the comprehensive revision to federal statutes governing all aspects of Medicaid managed care programs as set forth in Section 1932 of the Social Security Act and Title 42 of the *Code of Federal Regulations* (CFR), part 438 *et seq.* In support of these regulations and health plan contractual requirements, Delmarva evaluated and then assessed compliance for the following systems:

- Enrollee Rights and Protections—Subpart C Regulation
- Quality Assessment and Performance Improvement—Subpart D Regulation
  - Access Standards
  - Structure and Operation Standards
  - Measurement and Improvement Standards
- Grievance Systems—Subpart F Regulation

It is expected that each health plan will use the review findings and recommendations for operational systems improvement to become fully compliant with all standards and requirements.

Quality At A Glance

Ensuring quality of care for Medicaid managed care recipients is a key objective of the Medallion II program. Various indicators exist that serve as direct and proximate measures of the quality of care and services provided to Medallion II recipients. Along with access and timeliness, these indicators are essential components of a quality-driven system of care, which is vital for the success of the Medallion II program. Data obtained from clinical studies performed by Delmarva as well as through other avenues of data support the delivery of quality health care to the Medallion II population. The findings related to quality are reported in the following sections.

HEDIS

Three HEDIS measures served as proxy measures for clinical quality:

- Childhood Immunizations
- Adolescent Immunizations
- Breast Cancer Screening

Table 1 shows the results obtained by CareNet.

Table 1. 2005 HEDIS Quality Measure Results for CareNet

HEDIS Measure	2005 CareNet Rate	Medallion II Average	2004 National Medicaid HEDIS Average
Childhood Immunization Status	54.4%	58.1%	61.8%
Adolescent Immunization Status	43.5%	49.7%	51.8%
Breast Cancer Screening	46.4%	51.4%	55.8%

CareNet fell below the Medallion II average and the National Medicaid HEDIS average for all three quality measures. The results above display opportunities for improvement in regards to these areas of quality.

Performance Improvement Projects

In the area of PIPs, CareNet used the quality process of identifying a problem relevant to its population, setting a measurement goal, obtaining a baseline measurement, and performing targeted interventions aimed at improving the performance. After the remeasurement periods, qualitative analyses often identified new barriers that affect success in achieving the targeted goal. Thus, quality improvement is an ever-evolving process focused on improving outcomes and health status.

CareNet has implemented two PIPs:

- Increasing Adolescent Immunization Rates
- Increasing the Number of Members With Asthma to Receive Care According to the Guidelines

CareNet's PIP aimed at increasing the number of members with asthma to receive care according to the guidelines addresses an important opportunity for improvement for CareNet's member population based upon review of Medicaid HMO plan specific and national data. Asthma ranked in the top diagnoses for inpatient admissions, emergency departments visits and outpatient office visits.

CareNet's PIP related to increasing the number of members with asthma to receive care according to the guidelines seeks to decrease emergency department visits and acute hospital admissions for Medallion II enrollees who have been diagnosed with asthma. The PIP also includes a goal to increase flu vaccinations to enrollees with a diagnosis of asthma. This PIP, over time, addresses multiple care and delivery systems that have the ability to pose barriers to improved enrollee outcomes. Use of appropriate asthma medications has been demonstrated to improve long-term control for individuals with asthma and, as such, serves as a proxy measure for changes in health status.

CareNet conducted analysis and developed related interventions for each enrollee, provider, and administrative barrier identified. Interventions have focused primarily on enrollee and provider education, however, in 2004, identification and outreach to non-compliant enrollees was implemented as well as targeted case management services for identified high-risk enrollees.

A comprehensive quantitative analysis was performed following each re-measurement that compared result to goal/benchmark and prior performance, described reasons for any changes to goals, and identified any trends or changes in statistical significance. Improvement from baseline to remeasurement 5 was realized for the influenza vaccination rate, which was measured at 2% at baseline and at 31.26% at remeasurement 5. No improvement was seen in the acute hospital admission and emergency department visit rates. Based upon the continued deterioration in rates for acute hospital admissions and an acute emergency department visit rate nearly twice the baseline rate, it appears that the barrier analysis for these two indicators has been inadequate in identifying effective interventions to address opportunities for improvement. As a result, an analysis of findings, both quantitative and qualitative, should be completed focusing on an in-depth barrier analysis to address stalled improvement and the development of associated interventions that are timely, focused, and aggressive.

CareNet also implemented a PIP related to increasing adolescent immunization rates. CareNet analyzed its Medallion II demographic and utilization data and compared performance on select measures with national data. CareNet, in its analysis, identified a prevalence of children and adolescents in the health plan population and administration of immunizations has consistently ranked in the top 25 outpatient diagnostic categories. CareNet, through its PIP related to increasing adolescents' immunization rates, seeks to increase the adolescent rates for three separate immunizations (MMR, Hepatitis B, Varicella Zoster Virus) and two combo rates for specific immunizations included in the HEDIS adolescent immunization measure.

While this is considered to be a baseline review and assessment of the MCO's prior performance was not conducted, this PIP did address, over time, multiple care and delivery systems that have the ability to pose barriers to improved enrollee outcomes. Increases in adolescent immunization rates have been identified as valid proxy measures for improved health status.

Enrollee/family, provider, and administrative barriers were identified by CareNet. Educational interventions targeted at parents/guardians and providers as well as outreach to parents/guardians and partnering with the Virginia Department of Health Immunization Registry for data sharing appear to be reasonable interventions based upon the barriers identified.

Table 2 provides a summary of data results for both PIPs conducted by CareNet.

Table 2: PIP Performance Results

PIP Activity	Indicator	Baseline	#1	Remeasurement			
				#2	#3	#4	#5
Increasing the Number of Members With Asthma to Receive Care According to the Guidelines	Quantifiable Measure #1: Percent of eligible asthma members who had an influenza vaccination in the measurement year. Quantifiable Measure #2: Percent of eligible asthma members who had an acute hospital admission in the measurement year. Quantifiable Measure #3: Percent of eligible asthma members who had an acute ER visit in the measurement year.	1999: QM1: 2.0% QM2: 8.74% QM3: 18.58%	2000: QM1: 3.96% QM2: 10.72% QM3: 37.34%	2001: QM1: 3.60% QM2: 9.31% QM3: 34.27%	2002: QM1: 15.79% QM2: 9.04% QM3: 37.99%	2003: QM1: 29.43% QM2: 9.13% QM3: 39.23%	2004: QM1: 31.26% QM2: 11.35% QM3: 33.06%
Increasing Adolescent Immunization Rates	The percentage of enrolled adolescents who turned 13 years old during the measurement year, were continuously enrolled for twelve months immediately prior to their 13th birthday, and who were identified as having had, by the their 13th birthday, the following.: Quantifiable Measure #1: Second dose of MMR Quantifiable Measure #2 Three Hepatitis B vaccines Quantifiable Measure #3 One Varicella (VZV) vaccine Quantifiable Measure #4 Second dose of MMR and three Hepatitis B vaccines (Combo 1) Quantifiable Measure #5 Second dose MRR, three Hepatitis B and one Varicella (VZV) vaccine. (Combo 2)	2000: QM1: 30.54% QM2: 14.37% QM3: 15.57% QM4: 11.98% QM5: 8.98%	2001: QM1: 49.19% QM2: 27.42% QM3: 29.44% QM4: 24.19%% QM5: 16.53%	2002: QM1: 42.81% QM2: 29.74% QM3: 26.14% QM4: 24.51% QM5:14.38%	2003: QM1: 46.65% QM2: 34.36% QM3: 25.14% QM4: 28.77% QM5:16.20%	2004: QM1: 57.33% QM2: 56.25% QM3: 24.72% QM4: 43.47% QM5: 20.38%	

Operational Systems Review Findings

Within the operational systems review component of the quality review, CareNet was reassessed specifically in the following areas:

Enrollee Rights and Protections—Subpart C Regulations

- ER1. Enrollee Rights and Protections-Staff/Provider
- ER6. Advanced Directives

Quality Assessment and Performance Improvement—Subpart D Regulations

- QA3. 438.206 Availability of Services (b) (3)
- QA4. 438.206 Availability of Services (b) (4)
- QA20. 438.56 (c) Provider Enrollment and Disenrollment—Requested by Enrollee
- QA29. 438.242 Health/Management Information Systems

Grievance Systems—Subpart F Regulations

- GS1. 438.402 (a,b) Grievance System
- GS4. 438.404 (b) Content of Notice of Action
- GS6. 438.206 Handling of Grievances and Appeals—Special Requirements for Appeals

CareNet performed well in the areas of enrollee rights and protections- staff/provider, availability of services, provider enrollment and disenrollment, health/management information systems, grievance systems, and handling of grievances and appeals. Policies and procedures were revised for compliance in the areas shown above. An example of a significant area where CareNet has performed successfully in this review is with the availability of services. CareNet has policies and procedures to provide for a second opinion from a qualified health care professional within the network, or to provide for the enrollee to obtain one outside the network, at no cost to the enrollee. The area of grievance systems was found to be another core strength for CareNet. CareNet has policies that ensure that individuals who make decisions on grievances and appeals were not involved in previous levels of reviews or decision-making and are health care professionals with appropriate level of expertise in treating enrollee's condition or disease. Other aspects of grievance systems were found to be met as well.

CareNet was found to have opportunities for improvement in the areas of advanced directives and content of notice of action. For advanced directives relating to policies and procedures to inform enrollees that they may obtain a second opinion from a qualified health care professional within the network or outside the network if necessary, at no cost to the enrollee; a recommendation was provided. The recommendation for improvement suggests that CareNet specifically include language in the above policy that identifies how enrollees with be informed about the availability of a no cost second opinion, such as through the Member Handbook. An additional recommendation pertaining to content of notice of action suggests that CareNet

Notice of Action (NOA) letter contain the following language relating to benefit continuation and liability for costs of those services "the circumstances under which the enrollee has the right to request that benefits continue pending appeal resolution and the circumstances under which the enrollee may be required to pay the costs of services". In order to receive a finding of met in the next review, there must be evidence of the above required language in all NOA letters.

Two elements were partially met after review of CareNet's documents; however seventeen elements changed to met status since the last review. Most of the improvement areas were addressed within twelve months of the audit review period. CareNet effectively implemented the recommendations for quality improvement and corrected each area by this review period. The rapid correction of the previous review's opportunities for improvement is evidence that CareNet has a strong oversight process and commitment to improving care and services to its members.

Summary of Quality

CareNet demonstrates a quality-focused approach in administering care and services to its members. The plan exhibits an integrated approach to working with its members, practitioners, providers, and internal health plan departments to improve overall health care quality and services. The health plan also focuses resources toward evaluating the interventions that provide the most benefit toward improvement needs. Opportunities for improvement may be evident in the area of quality pertaining to HEDIS measures and reassessed elements from the operational systems review.

Access At A Glance

Access to care and services historically has been a challenge for Medicaid recipients enrolled in fee-for-service programs. Access is an essential component of a quality-driven system of care. The intent of the Medallion II program is to improve access to care. One of DMAS's major goals in securing approval of the 1915(b) Medicaid waiver application was to develop managed care delivery systems that would remove existing barriers for Medicaid recipients, thereby improving their overall health status, increasing their quality of life, and reducing costly health expenditures related to a fragmented system of care. The findings with regard to access are discussed in the following sections.

HEDIS

From a HEDIS perspective, access and availability of care are addressed through the Prenatal and Postpartum Care HEDIS measure. Two rates are calculated for this measure:

- Timeliness of Prenatal Care
- Postpartum Check-up Following Delivery

Table 3 shows the results obtained by CareNet.

Table 3: 2005 HEDIS Access Measure Results for CareNet

HEDIS Measure	2005 CareNet Rate	Medallion II Average	2004 National Medicaid HEDIS Average
Timeliness of Prenatal Care	91.1%	82.8%	76.0%
Postpartum Check-up Following Delivery	58.5%	57.8%	55.2%

CareNet scored above the Medallion II average and the National Medicaid HEDIS average for the "Timeliness of Care" rate and for the "Postpartum Check-up Following Delivery" rate. Postpartum care is impacted by the health plan's access to correct demographic information for outreach to postpartum members. These results regarding access appear to be strengths for CareNet.

Performance Improvement Projects

CareNet's PIPS focused upon improvement of clinical indicators. However, within the barrier analyses for each project, potential access barriers were also examined. The identification of access barriers was found in CareNet's PIP aimed at increasing the number of members with asthma to receive care according to the guidelines.

Barriers were identified related to member and provider lack of awareness of benefits of consistent focus on a chronic disease such as asthma. In 2004, identification and outreach to non-compliant enrollees and targeted case management services for identified high-risk enrollees were implemented to improve member outcomes.

Operational Systems Review Findings

Delmarva's operational systems review of CareNet showed that the following review requirements were reexamined and reflect adequate proxy measures for access:

Enrollee Rights and Protections—Subpart C Regulations

- ER3. Information and Language Requirements (438.10)
- ER5. Emergency and Post-Stabilization Services (438.114, 422.113c)
- ER7. Rehabilitation Act, ADA

Quality Assessment and Performance Improvement—Subpart D Regulations

- QA8. 438.208 (c) (4) Direct Access to Specialists

Through a desk review conducted for CareNet, Delmarva comprehensively reassessed elements from the previous year's review that were deficient and found that five of the areas have improved to met status within the year prior to this review. CareNet performed well in areas of access to include an element relating to

information and language requirements, emergency and post-stabilization services, the Rehabilitation Act, and direct access to specialists. Policies and procedures were revised prior to this review to ensure compliance within these areas.

An example of a significant area where CareNet has performed successfully in this review is with information and language requirements. CareNet has provided written material in alternative formats and in an appropriate manner that takes into consideration the special needs of those who, for example, are visually limited or have limited reading proficiency. An additional area of strength for CareNet is with emergency and post-stabilization services. CareNet has policies and procedures in place that define emergency and post-stabilization situations, a description on what to do in an emergency, a telephone number and instructions for obtaining advice on getting care in an emergency, and that prior authorization is not needed. However, it is recommended that CareNet revise the Member Handbook to eliminate the requirement for pre-approval of post stabilization care to be consistent with this policy. A final area of strength for CareNet pertains to direct access to specialists. CareNet has policies and procedures that allow an enrollee with special needs to access a specialist as is appropriate for the condition and identified needs.

Only one element is partially met for this review and pertains to information and language requirements. For information and language requirements relating to policies and procedures in place to inform enrollees and potential enrollees that information is available in alternative formats and how to access those formats; a recommendation was provided. The recommendation for improvement suggests that CareNet revise the above policy to include how well it will communicate the availability of written MCO enrollee materials information in an alternative formats for enrollees and potential enrollees who are visually impaired or have limited reading proficiency.

After completion of the review, Delmarva conducted an assessment of CareNet's corrective action process. CareNet effectively implemented recommendations related to most of the elements found to be partially met or not met and corrected every identified opportunity within 12 months of the report findings.

Summary of Access

Overall, access is an area of strength for CareNet and supports the health plan's intent as a quality-driven system of care. Combining all the data sources used to assess access; CareNet addressed the areas where the health plan showed vulnerability and corrected identified access issues, furthering the plan in its goal to implement a managed care delivery system that addresses existing barriers for Medicaid recipients.

Timeliness At A Glance

Access to necessary health care and related services alone is insufficient in advancing the health status of Medallion II recipients. Equally important is the timely delivery of those services, which is an additional goal

established by DMAS for the systems of care that serve Medallion II recipients. The findings related to timeliness are revealed in the sections to follow.

HEDIS

Timeliness of care was investigated in the results of the following HEDIS measures:

- Well-Child Visits in the First 15 Months of Life
- Well-Child Visits in the Third, Fourth, Fifth, and Sixth Year of Life
- Adolescent Well-Care Visits

All Medallion II managed care plans were required to submit these measures. Table 4 shows the results obtained by CareNet.

Table 4. 2005 HEDIS Timeliness Measure Results for CareNet

HEDIS Measure	2005 CareNet Rate	Medallion II Average	2004 National Medicaid HEDIS Average
Well Child Visits in the First 15 Months of Life - 6 or more visits	**47.1%**	**35.0%**	**45.3%**
Well Child Visits in the Third, Fourth, Fifth, and Sixth Year of Life	**51.5%**	**59.7%**	**60.5%**
Adolescent Well-Care Visits	**24.0%**	**31.0%**	**37.4%**

The "Well Child Visits in the First 15 Months of Life" measure exceeded the Medallion II average and the National Medicaid HEDIS average. The "Well Child Visits in the Third, Fourth, Fifth, and Sixth Year of Life" fell below the Medallion II average and the National Medicaid HEDIS average. Similarly, the "Adolescent Well-Care Visits" measure fell below both comparison averages.

Performance Improvement Projects

Timeliness was a focal area of attention in CareNet's PIPs. Member focused efforts consisted of assuring that members were educated about key feature of asthma disease management. Barriers related to timeliness issues focus upon the lack of timely provision of care or services due to missed opportunities.

Issues related to timeliness of services may very likely be impacted by access. CareNet's PIPs aimed at increasing the number of members with asthma to receive care according to the guidelines and increasing adolescent immunization rates are HEDIS-related and focus upon services received (access) as well as the timeframe in which the service was provided (timeliness).

Operational Systems Review Findings

Delmarva's desk review findings showed that the following review requirements were reassessed and reflect adequate proxy measures for timeliness:

Enrollee Rights and Protections—Subpart C Regulations

- ER4. 42 C.F.R. 431, Subpart F, and the Code of Virginia, Title 2.1, Chapter 26, (Privacy Protection Act of 1976) and the Health Insurance Portability and Accountability Act of 1996

Quality Assessment and Performance Improvement—Subpart D Regulations

- QA13. 438.210 (d) (1) Timeframe for Decisions—Standard Authorization Decisions
- QA14. 438.210 (d) (2) Timeframe for Decisions—Expedited Authorization Decisions

Grievance Systems—Subpart F Regulations

- GS8. 438.408 Resolution and Notification: Grievances and Appeals—Expedited Appeals
- GS9. 438.408 (b-d) Resolution and Notification
- GS10. 438.408 (c) Requirements for State Fair Hearings
- GS11. 438.410 Expedited Resolution of Appeals, GS. 438.424 Effectuation of Reversed Appeal Resolutions

CareNet performed well in the areas of privacy protection and the Health Insurance Portability and Accountability Act of 1996, timeframe for decisions—standard authorization decisions and expedited authorization decisions, resolution and notification, requirements for state fair hearings, and expedited resolution of appeals. Policies and procedures were revised for compliance in the areas shown above. An example of a significant area where CareNet has performed successfully in this review is with timeframe for decisions. CareNet provides decision notice as expeditiously as enrollee's health condition requires, not exceeding 14 calendar days following receipt of request for service, with possible extension up to 14 additional calendar days if enrollee requests extension or MCO justifies a need for additional information.

Also, CareNet has policies/procedures relating to the extension of time frames for expedited authorizations allowed under the state contract. Another area of strength for CareNet relates to resolution and notification. CareNet has a process for extension, and for notifying enrollees of reason for delay. CareNet makes reasonable efforts to provide the enrollee with prompt verbal notice of any decisions that are not resolved wholly in favor of the enrollee and shall follow-up within two calendar days with a written notice of action.

Delmarva identified two elements pertaining to resolution and notification and requirements for state fair hearings that were found to be partially met after this review. Both of these elements did not demonstrate any improvement from the last review. A recommendation for resolution and notification pertaining to decisions by the MCO to expedite appeals in writing and include decision and date of decision is for CareNet

to revise the Southern Health Policies and Procedures: Fast (Expedited) Appeal Process CareNet Members policy was provided. Revision of this policy would include the requirement for date of appeal decision in the written notification to the enrollee. The final recommendation in regards to requirements for state fair hearings is for CareNet to revise the three new Southern Health Policies and Procedures, UM Appeal Process, Administrative Appeal Process, and Fast (Expedited) Appeal Process for CareNet Members to include time frame for delivery of the monthly appeals report to DMAS as well as required report content.

However, CareNet effectively addressed the other ten elements identified as deficient in the previous review, which have all now evolved to met status. CareNet corrected most of the access related deficiencies within twelve months, which displays their commitment to continuous improvement.

Summary for Timeliness

CareNet demonstrates an awareness of the importance of timeliness in the delivery of overall quality care and service through the identification of timeliness barriers, which often are identified as access issues. CareNet is encouraged to continue to address opportunities for improvement in the area of timeliness.

Overall Strengths

Quality:

- Commitment of CareNet management staff towards quality improvement as evidenced by the rapid response and resolution of most the deficiencies cited during the operational systems review.
- CareNet met the majority of the re-assessed quality elements for the operational systems review.
- Information system capabilities for performance measures to include data capture, general information systems, centralized processing of data, provider data, data sharing, and eligibility programming.
- Reporting methods for performance measures include staff experience, communication, documentation, and a team approach.
- Improvements realized since baseline related to the influenza vaccination rate measure found in CareNet's PIP aimed at increasing the number of members with asthma to receive care according to the guidelines.

Access:

- CareNet demonstrates better access to prenatal care and postpartum follow-up than the Medallion II program in aggregate and the Medicaid program nationally.
- CareNet met all except one of the re-assessed access elements for the operational systems review.
- Recognition by CareNet that quality of care issues are impacted by access barriers.

Timeliness:

- CareNet met the majority of the re-assessed timeliness elements for the operational systems review.

- CareNet's partnership with the practitioner network to address education about asthma in the member population.

Recommendations

This section offers DMAS a set of recommendations to build upon identified strengths and to address the areas of opportunity within the existing programs. These recommendations draw from the findings of those data sources individually and in the aggregate. Delmarva's recommendations for CareNet are as follows:

- CareNet is encouraged to continue efforts to increase data completeness.
- CareNet is encouraged to continue employing successful performance measure reporting tactics.
- General quality improvement and teamwork training is also recommended as these skills will likely lead to efficiencies in performance measure reporting.
- Improve documentation of processes and methodologies to assist during staff changes would be beneficial.
- Develop standardized provider data entry protocols and methodologies to identify locations of member medical records could reduce the need for multiple unsuccessful medical record chases.
- Develop or revise policies and procedures of the elements found to be deficient and/or make appropriate improvements in order for the deficiencies to be met in next year's EQRO review.
- Perform periodic monitoring within the areas identified in the operational systems review as deficient to make certain that the actions undertaken to correct the issues remain effective.
- Perform further investigation of low rated measures identified by HEDIS.
- Assess the disparities in quality of care and/or services among differing ethnic population within the managed care membership. Understanding this phenomenon will enable focused resource allocation.
- Perform root cause analyses for project interventions that fail to improve performance. This activity will enable CareNet to better identify barriers to change and more effectively allocate resources to achieve systemic improvements.

References:

1. Centers for Medicare and Medicaid Services (CMS). (2002, June). *Final Rule: Medicaid Managed Care; 42 CFR Part 400, et.al. Subpart D- Quality Assessment and Performance Improvement*. Retrieved December 9, 2004, from CMS website: http://www.cms.hhs.gov/medicaid/managedcare/f4289.pdf

2. Centers for Medicare and Medicaid Services (CMS). (2003, January). *Final Rule: External Quality Review of Managed Care Organizations and Prepaid Inpatient Health Plans; 42 CFR Part 438.300 et.al.* Retrieved November 1, 2004 from CMS website: http://www.cms.hhs.gov/medicaid/managedcare/eqr12403.pdf

3. Institute of Medicine (IOM), Committee on the National Quality Report on Health Care Delivery, Board on Health Care Services. (2001). *Envisioning the National Health Care Quality Report*. Retrieved February 24, 2005, from the National Academies Press website: http://www.nap.edu/html/envisioning/ch2.htm

4. National Committee for Quality Assurance (NCQA). (2003). *Standards and Guidelines for the Accreditation of* MCOs.